ACIP Comments June 20, 2025.

The UNIQUE property of COVID-19 spike mRNA gene therapy products causing high levels of persistent spike IgG1 and IgG3 in the Upper Respiratory Tract (URT) likely contributed to increased pathology and sudden deaths related to microclotting and/or myocarditis following the transmission of these deadly IgG1/3 antibodies that bind complement (and initiate clotting) with SARS-CoV-2 variants and with shed spike mRNA gene therapy exosomes from the upper respiratory tract (URT).

From

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Synopsis

Whether or not you believe in spike mRNA shedding, shedding causing deaths or shedding causing many deaths; or understand how the shedding of unadulterated HERV-K102 protector particles from the upper respiratory tract (URT) likely generates and spreads herd immunity; the critical point that the ACIP must acknowledge and act upon, is the undeniable truth that the COVID-19 spike mRNA gene therapy technology uniquely caused the high production of spike IgG1 and IgG3 antibodies in the URT after the second dose. These IgG subclasses are excellent at binding complement and can drive clotting when bound to cognate antigen. SARS-CoV-2 virions transmitted from the URT of persons who received two or more doses of the spike mRNA shots, would exhibit a higher probability of inducing myocarditis and microclotting symptoms including death than SARS-CoV-2 virions transmitted before the mRNA vaccinations were introduced.

Evidence from Bowe B et al., [Nature Medicine, 2022] CONCERNING 5.8 MILLION VETERANS, indicated that the 30 DAY reinfection risk of **death was 1/100,** of **hospitalization was 1/14.3** and of suffering a long term **health sequela was ¼.** One could argue that these INCREASED RISKS that involved primarily microclotting type sequalae pertained to the probability of the co-transmission of the deadly spike IgG1/3 antibodies with the newly selected SARS-CoV-2 virions and/or with spike mRNA commandeered HERV-K102 particles (shedding of spike mRNA gene therapy products). Accordingly, with these extraordinary odds, the ACIP must conclude any technology like spike mRNA gene therapy that produces high persistent levels of complement binding spike antibodies in the URT must be avoided and hereby banned for use in humans and animals.

ACIP with NIH needs to prioritize the study of HERV-K102 protector particle shedding creating trained (innate) immunity in M1-like foamy macrophages, its apparent role in generating herd immunity, and the role of the spike mRNA LNPs in converting the protector HERV-K102 particles into bioweapons. Also since HERV-K102 particles contain functional reverse transcriptase and integrase, the contamination of these particles in the sebocytes in the URT by spike mRNA could greatly increase the risk of spike mRNA integration when transmitted to humans or their microflora.

In retrospect the use of mRNA gene therapy technology was a disaster which could have been mitigated in part by following the FDA 2015 guidance for extended shedding and integration studies prior to the marketing of any mRNA gene therapy products.[[1]](#footnote-1),[[2]](#footnote-2) It would have also significantly helped if these shots were not mandated given that it unconstitutional to mandate any medical intervention, and more specifically the FDA forbids the mandating of any product or medical intervention that has not met the standard for safety assessment such as products placed on the market by Emergency Use Authorization. Finally, the failure to properly monitor and/or report adverse events and deaths in a timely manner to inform vaccine candidates of the real risks, when combined with the focus by the previous White House Administration in quelling the truth about the lack of safety of the mRNA gene therapy shots, are thought to be main reasons for the extent of injuries and deaths over the past 4 years. As a minimal requirement, the vaccination record should have been linked to the mortality database to determine the amount of iatrogenic deaths linked to vaccination including shedding deaths as was performed for England [1] and made available in real time. Why the previous ACIP panel did not absolutely require this data to be collected and provided publicly in real time is beyond belief.

A diagram of a virus

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**Image 1**. From reference [1].

HERV-K102, the protector foamy retrovirus of humans encoded in the human genome at 1q22, becomes activated by viruses [2] to produce high levels of the protector HERV-K102 particles in M1 foamy macrophages that are subsequently released by cell lysis [3]. In the upper respiratory tract (URT) there are highly specialized M1-like foamy macrophages that constitutively produce HERV-K102 particles and release them as a waxy substance called sebum [4,5]. These are the sebocytes, the cells with identical morphology to M1-like foamy macrophages found in the sebaceous glands that line the mucosa such as the URT.

However, when dirty process 2 lipid nanoparticles (LNPs) containing mRNA produced in *E. coli* are used for mass inoculation, this is proposed to result in the targeting of the spike laden LNPs to the sebocytes in the URT via antibody dependent enhancement (ADE) of infection into macrophages after the second dose of spike mRNA gene therapy products. The high levels of **spike IgG1 and IgG3 are first produced in the URT upon the second dose of spike mRNA** and **is uniquely a property of the spike mRNA gene therapy products** but not cDNA gene therapy products (adenovirus-based vaccines) or natural infections [6]. From work of Bansal et al, 2021 [7], these CD9 exosomes (meaning they come from M1-like foamy macrophages [8] and thus likely represent HERV-K102 particles [3]), become contaminated with spike protein and they are made for about for 3-4 months after the second dose [7]. This mechanism shown in Image 1, helps to explain how the shed compromised HERV-K102 particles from the URT when complexed to the spike IgG1 and IgG3 antibodies could result in sudden or unexpected deaths relating to microclotting and/or myocarditis in the recipient. See Image 2 population data from England for evidence consistent with this notion.

A screenshot of a medical report

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**Image 2.** Population-Based Data From England and Changes to Mortality Rates by Vaccination Status and Dose in 65 to 75 Year Olds [1].

A positive control for the diminishing of mortality rates is shown in E: Omicron Era which infected the non-vaccinated and the vaccinated. Following the first dose [A], which is known to generate trained innate immunity which provides heterologous protection against all-cause mortality [9] and in consideration that trained innate immunity is generated by HERV-K102 particle production in the M1-like foamy macrophages [4,5], the results in A indicate (with the exception of non-COVID-19 deaths due to Pfizer spike mRNA direct toxicity) that the shed HERV-K102 protector particles diminished COVID-19 deaths in both the vaccinated and unvaccinated. However, with subsequent doses the level of protection by the putative shed HERV-K102 particles on non-C19 deaths in the unvaccinated dropped (-22%, -10 %, -1 %) such that by the 4th dose there was an increase in non-C19 deaths (plus 29%). This data implied that with each Pfizer spike mRNA dose more and more of the HERV-K102 protector particles shed from the URT were being compromised by the dirty LNPs and turned into bioweapons (see Image 1).

A graph of covid-19

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**Image 3.** The highest peak of putative shedding of compromised HERV-K102 particles (ie, converted to bioweapons) occurred in June/July 2021 in England [1] Also shedding seemed to cause deaths in the unvaccinated albeit at levels about 3-fold less.

Note that as expected the highest peaks were associated with the second dose of the Pfizer mRNA gene therapy shot and each round of shedding following the administration of the Pfizer mRNA gene therapy shots typically lasted 3 to 4 months as expected based on the work of Bansal et al, 2021 [7]. Later after the 4th dose in the 75+ (and other high risk groups) we see a relative increase in mortality in the unvaccinated compared with the vaccinated in fall 2022. It is tempting to speculate that the relative decrease in deaths in the vaccinated during this time could have been due to vaccinated individuals converting their spike IgG1/3 in the blood to the IgG4 which does not bind complement [6] and thus placed them at reduced risks.

A graph of a number of patients with covid-19

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**Image 4.** The infamous Cleveland Clinic data [10] supports the contention that the spike IgG1/3 antibodies in the URT never get converted to IgG4 **although this needs to be directly examined.**

This means that the transmission of SARS-CoV-2 from the URT of a person who has had two doses of the spike mRNA shots, most likely occurs in a complex with high levels of spike antibodies that bind complement and thus, this complex can easily initiate complement binding in the new host when it enters the blood in the microcirculation deep in the lungs. That antibodies to spike protein can be transmitted by exhalation has been shown [11].

A table of cases with numbers and a number of cases

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**Image 5.** Early Data Warning of High Lethality of Transmitted DELTA Variants In England in June/July 2021 but which disappeared by September 2021.

I posted this data in late September 2021 on LinkedIN, and I was subsequently banned by October 23, 2021 for releasing data implicating the dangers of the Pfizer spike mRNA second shot particularly when compared with those who got only one dose. In fact, the data implicated for the 50+ age group that the COVID-19 spike mRNA was killing about 1 % of the people who got the second shot (top panel) and that there was about a 50% mortality in hospitalized delta cases that had had delta transmitted to them in June/July 2021. Again with time, these risks abated by September 2021. However, since the data pertained to delta infections only, this means the enhanced mortality was likely caused by SARS-CoV-2 being transmitted with high levels of complement binding IgG1 and IgG3. The levels of antibody in the URT would naturally diminish with time, at least until the next shot or infection.

A close-up of a document

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**Image 6.** Mortality rates per 100,000 person years by vaccination status for England [1].

The CDC and in Canada PHAC, should have linked the vaccination record to the mortality database to derive the monthly estimates for mortality and delivered this data in real time. Here we see convincing evidence that the spike mRNA shots should have been halted by the first week in February 2021 in England.

A close-up of a medical information

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**Image 7.** Proposed Algorithm for removing unsafe (grandfathered in) vaccines from the Market.

If instead the CDC had set up a special algorithm such as the one above, it is quite possible the deadly spike mRNA gene therapy shots would have been removed from the market in December 2020 sparing Americans the vast majority of injuries and deaths associated with the mRNA gene therapy technology.

A close-up of a graph

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**Image 8.** Data on reinfection [12] compared with no reinfection (but infection in 2020) implies these deaths involved SARS-CoV-2 transmitted with the spike IgG1/3 antibodies. All cases of reinfection showed these trends essentially irrespective of vaccination status.

A graph of different colored bars

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**Image 9**. Data on reinfection [12] implied highly elevated risks of deaths (1/100), hospitalizations (1/14) and injuries (1/4).

A close-up of a chart

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**Image 10.** The above data for England [1], only pertains to iatrogenic deaths that did not involve SARS-CoV-2 infections or diagnoses with COVID-19, and so we know the shedding deaths captured are independent of SARS-CoV-2. Note that the shedding deaths to COVID-19 deaths was 5.7-fold elevated implying shedding deaths more commonly lead to injuries and deaths.

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